Sample 837 Scenarios

The sample scenarios are for test and education purposes. The information is test data and does not represent actual insurance carriers, employers, injured employees, or health care providers. The information may appear to be real or confidential information. However, this is done in order to ensure the test data passes validation edits.

TX 837 – Scenario 3

Unbundling Professional

Darlene Davidson is a single female, born 06/04/69. She lives at 5720 Green Drive in Dallas, TX 72309. Her telephone number is (214) 836-5527 and social security number is 224-17-3272.

Darlene works at Bagels, Etc. located at 234 Main Street in Dallas, TX 72314. Bagels, Etc.'s telephone number is (214) 472-1462.

Bagels, Etc. is covered under policy number 147643A472 by Texas Insurance Company. Texas Insurance Company's telephone number is (312) 555-1470, FEIN is 76-5332244, and the address is 789 Airport Road Austin, TX 60606-1234.

- On 09/18/2002 became ill with nausea and headache after mopping the floor with ammonia and bleach at Bagels, Etc.
- On 08/15/2003 Darlene presented in Dr. Robert Smudge's office, Main Medical, located at 345 Lower Level, Arlington, TX 62308.
- Dr. Smudge's state medical license is MDJ0432TX
- On 08/16/2003 Main Medical sent a bill to Texas Insurance Company for total charges of $85.00:
    - 99213; 1 unit; $50.00
    - 36000; 1 unit; $10.00
    - 80053; 1 unit; $25.00
- On 09/06/2003 Texas Insurance Company received the medical bill from Dr. Smudge.
- On 09/10/2003 Texas Insurance Company sent payment of $66.00 to Dr. Rudolf:
    - $48.00 for 99213 using ARC W1
    - $0.00 for 36000 using ARC 97 as it is global to 80053
    - $18.00 for 80053 using ARC W1

Texas Insurance Company is required to report all medical bill payment information to the Texas Workers' Compensation Commission (TWCC) within 30 days of payments made.

On 09/23/03 Texas Insurance Company sent a transaction to TWCC covering the reporting period of 08/02/03 to 09/15/03. The insurance carrier claim number for Darlene's claim is 14000714D. The unique bill number assigned by Texas Insurance Company for Darlene's bill was 111123.

PLEASE DO NOT STAPLE IN THIS AREA

Texas Insurance Company
789 Airport Road
Austin, TX 60606-1234

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 224-17-3272

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Darlene Davidson

3. PATIENT'S BIRTH DATE MM DD YY: 06 04 69 SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Bagels, Etc.

5. PATIENT'S ADDRESS (No., Street): 5720 Green Drive

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☒

7. INSURED'S ADDRESS (No., Street): 234 Main St.

CITY: Dallas STATE: TX

8. PATIENT STATUS: Single ☒ Married ☐ Other ☐ Employed ☒ Full-Time Student ☐ Part-Time Student ☐

CITY: Dallas STATE: TX

ZIP CODE: 72309 TELEPHONE (Include Area Code): (214) 836-5527

ZIP CODE: 72314 TELEPHONE (INCLUDE AREA CODE): (214) 472-1462

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☒ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE:

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY: 09 18 02 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE:

17a. I.D. NUMBER OF REFERRING PHYSICIAN:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE:

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 987.9
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
08 15 03	08 15 03	11		99213		1	50 00	1				
08 15 03	08 15 03	11		36000		1	10 00	1				
08 15 03	08 15 03	11		80053		1	25 00	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN: 435621987 ☒

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE: $ 85 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Robert Smudge MDJ0432TX

08/16/2003

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Main Medical
345 Lower Level
Arlington, TX 62308

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Main Medical
345 Lower Level
Arlington, TX 62308

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500